COUNTY MEDICAL SERVICES PROGRAM (CMSP)
MEDI-CAL LINKAGE EVALUATION

Case name: _____ Case number: _____

Name of person completing form: _____ Date: _____

To help us determine your eligibility for medical assistance through the County Medical Services Program or the Medi-Cal Program, please answer the following questions:

	YES	NO
1. Are you applying for another person?	☐	☐
If the answer to this question is yes, for whom are you applying? _____		
Please answer the following questions for the person for whom you are applying. If the answer to this question is no, please answer the following questions for yourself.		
2. Is applicant a resident of this county? If no, which county? _____	☐	☐
3. Is applicant under 21 years of age?	☐	☐
4. Is applicant 65 years of age or older?	☐	☐
5. Is applicant legally blind?	☐	☐
6. Is applicant unable to work because of a physical or mental illness, disability, or impairment that is expected to last for longer than one year?	☐	☐
7. Is applicant receiving state disability benefits?	☐	☐
8. Is applicant currently receiving Social Security Disability or SSI/SSP benefits? ***OR*** Has applicant applied for Social Security Disability or SSI/SSP benefits within the past six months? ***OR*** Is applicant planning to immediately apply for Social Security Disability or SSI/SSP benefits?	☐	☐
9. Does applicant live in a nursing home?	☐	☐
If yes, Name: _____ Address: _____ _____ _____		
10. Is applicant receiving homemaker chore/in-home supportive services?	☐	☐
11. If applicant is an Indochinese refugee or Cuban/Haitian entrant, has applicant lived in the United States for less than 19 months?	☐	☐

	YES	NO
12. Is there a child younger than 21 years of age living in applicant's home?	☐	☐
If yes, is one of the child's parents:		
a. Deceased?	☐	☐
b. Not living in the home?	☐	☐
c. Unemployed?	☐	☐
d. Over 65 years of age?	☐	☐
e. Legally blind?	☐	☐
f. Unable to work because of a physical or mental impairment that is expected to continue for more than one month?	☐	☐
13. Is applicant pregnant?		
14. Is applicant currently receiving Aid to Families with Dependent Children (AFDC) benefits? ***OR*** Has applicant applied for AFDC benefits? ***OR*** Is applicant planning to immediately apply for AFDC benefits?	☐	☐
15. Is applicant a Veteran?	☐	☐
If yes,		
Branch:_____		
Dates of service: _____		
16. Is applicant receiving Veteran benefits? ***OR*** Has applicant applied for Veteran benefits? ***OR*** Is applicant planning to immediately apply for Veteran benefits?	☐	☐
17. Is applicant currently in the hospital?	☐	☐
If yes,		
a. Is hospitalization due to illness?	☐	☐
If yes, expected length of stay:_____ days.		
b. Is hospitalization due to accident?	☐	☐
If yes, expected length of stay:_____ days.		
Name of third party involved in accident:		
_____		
c. Address of hospital:		
_____		
_____		

If one or more of questions number 2 through number 17 is checked "yes," review for Medi-Cal eligibility. If not eligible for Medi-Cal, review for County Medical Services Program eligibility.